DELINEATION OF PRIVILEGES RECORD

For use of this form, see AR 40-68; the proponent agency is OTSG

1. PERIOD FROM TO

2. Check the Appropriate Category

	A. Anesthesia		I. Pediatrics		Q. Nurse Practitioners *(Adult)*
	B. Dentistry		J. Podiatry		R. Nurse Practitioners *(Pediatric)*
	C. Family Practice		K. Psychiatry		S. OB/GYN Nurse Practitioners
	D. Internal Medicine & Subspecialty		L. Psychology		T. Physician Assistants
	E. Neurology		M. Radiology/Nuclear Medicine		U. Emergency Medicine
	F. Obstetrics & Gynecology		N. Surgery		V. Other Specialty *(Specify)*
	G. Optometry Service		O. Nurse Anesthetists		
	H. Pathology		P. Nurse Midwives		

3. Recommendations

A. MEDICAL TREATMENT FACILITY/DENTAC	B. STATUS	C. CLINICAL PRIVILEGES
	☐ (1) Temporary ☐ (2) Provisional ☐ (3) Courtesy ☐ (4) Consulting ☐ (5) Full *(Appointment Status)*	☐ (1) Granted as Requested ☐ (2) Modified as Recommended ☐ (3) Other *(See Remarks)*

D. DEPT./SVC *(Specify)*	E. DATE	G. CREDENTIALS COMMITTEE	H. DATE

F. SIGNATURE	I. SIGNATURE

4. Approval

A. NAME OF HOSPITAL/DENTAC COMMANDER	B. SIGNATURE	C. DATE

5. Remarks

6. Practitioner's Education/Training Update

A. BOARD ELIGIBLE FROM *(Date)*	B. BOARD EXAMINATION TAKEN *(Date)* ☐ Total ☐ Partial	C. BOARD CERTIFIED ☐ No ☐ Yes *(Give Name of Board)*
D. RECERTIFICATION *(Board and Date)*	E. UTILIZED IN PRIMARY SPECIALTY	F. YEARS AND DATES OF SPECIALTY TRAINING *(Specify only training since initial application)*
G. TOTAL HOURS OF CONTINUING EDUCATION THIS PERIOD	H. TOTAL HOURS OF SUB-SPECIALTY BOARD THIS PERIOD *(Specify)*	J. NAME OF APPLICANT OR PRACTITIONER

I. MEMBERSHIP IN SPECIALTY SOCIETY(IES) *(Specify)*	K. SIGNATURE	L. DATE